STATE OF ALASKA
AMERICANS WITH DISABILITIES REASONABLE ACCOMMODATION REQUEST

Documentation in Support of Request: Employee Release

I hereby authorize _____ to provide the medical information requested by my employer. The information will be used to evaluate my request for reasonable accommodation under the Americans With Disabilities Act.

_____ _____
Employee Name (Please print) Work Telephone

_____ _____
Signature Date

Attachment:

___ Form "Documentation in Support of Request: Provider Information"
OR
___ Letter from employing agency requesting provider information